Care Quality Commission

Loga Care Limited

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Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

This inspection took place on 2 and 5 February 2015 and was announced. Loga Care Limited provides 24 hour live-in care for adults of all ages with a range of health care needs. Care staff live in people's home to provide their care. People may experience dementia or have a physical or learning disability. Loga Care Limited also provides a live-in palliative care service. There were 99 people using the service at the time of the inspection. The service was last inspected on 22 April 2013 and no breaches of the regulations were identified.

The service has a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Everyone we spoke with said they felt safe. One said "Safe, absolutely" and another said they were "100%

Summary of findings

safe." Staff had completed safeguarding training and had access to guidance. They were able to recognise if people were at risk and knew what action they should take. The registered manager had taken action when people had been identified as at risk and learning had taken place. People were kept safe as safeguarding incidents were reported and acted upon.

People had comprehensive risk assessments. Where risks had been identified there were plans to manage them effectively. Staff understood risks to people and followed guidance. Staff were alert to changes in people's usual presentation. They recorded incidents and reported them to the office staff, who then took appropriate action such as liaising with health professionals.

There were sufficient staff to provide people's care. Additional staff could be provided at short notice. People were safe as staff underwent comprehensive pre-employment checks.

One person told us they took their own medicine and the care staff supported them with re-ordering medicine. Staff undertook medicines training and had a medicines competency check. Staff had been required to update their medicines training if they made an error but the provider informed us they would now require all staff to update this training annually. Staff followed guidance and sought advice as required. People's medicines were managed safely.

The provider had increased the length of the staff induction programme. Staff completed further training relevant to people's needs and were supported to undertake professional qualifications. Systems were in place to support staff and monitor their work. People's care was provided by staff who were sufficiently trained and supported.

Staff completed training on the Mental Capacity Act (MCA) 2005 and understood their role. Where people lacked the capacity to consent to their care relevant guidance had been followed. The provider was aware of anyone who was legally appointed to make decisions for people. They contacted advocacy services for people where required. The provider had not documented in their assessment why they believed people lacked capacity in accordance with good practice. They have informed us they have taken action to address this. The CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to community services. The provider is required to submit an application to the Court of Protection if they assess a person's liberty is restricted. The registered manager had completed relevant training and was aware of case law.

People's needs in relation to nutrition and hydration were documented. People received appropriate support to ensure they received sufficient to eat. Meals reflected people's dietary needs and preferences.

Everyone we spoke with said care staff were caring. One said, "She really cares" another commented "The one I've got at the moment is excellent." People told us staff treated them with dignity and respect. Staff were observed to treat people with dignity and respect. The ability and suitability of staff to form caring relationships with people was assessed as part of their recruitment process. People were matched with suitable staff and received information about staff on which to base their choice.

Staff worked with health care agencies to provide people with palliative care at home in accordance with their wishes. Staff who worked with people receiving palliative care were experienced and had training. The provider was arranging additional staff training to further improve end of life care planning.

People felt involved in their care planning and making decisions about their care. People's needs were assessed prior to the commencement of the service. As staff familiarised themselves with people's preferences and their needs, their care plans were amended. Care plans were personalised. People were supported to maintain their independence.

People experienced smooth transitions in their care between staff. Care staff had adequate time to complete handovers of the person's care and these were documented. This provided the incoming care staff with up to date information about people's needs.

The registered manager ensured people had information and support to make complaints. Where complaints were made they were investigated and actions taken in response. Complaints were analysed for themes and where these had been identified action had been taken.

Summary of findings

Staff had received training in the ethos and values of the provider as part of their induction. Staff were seen to uphold the provider's values in the course of their work with people.

The majority of people told us there were good communications from the office and they knew who to speak with. Staff were encouraged to speak with the office about any concerns they had about people's care. They felt able to do this openly and without fear of retribution. The registered manager had noted a culture of under reporting of incidents amongst staff when they started. They had taken effective action to ensure staff knew what they should report and how.

There had been a change in the ownership of the company providing the service and management in the past six months. Staff felt supported by the new leadership. The new management understood the challenges facing the service in relation to managed growth and staffing. They were taking measures such as increasing office staffing and improving the IT systems to support growth. There were systems in place for the provider to receive reports on the quality of the service provided. People's care was provided by management that was managing the growth of the business and monitoring quality.

Most people said someone from the agency called two or three times a year to monitor the quality of care provided and to check staff performance. People's feedback on the service was sought through telephone calls when there had been a change in staff. People's views had been sought through the annual quality survey. The provider intended to develop an action plan from the next survey, to learn from people's experiences.

The registered manager worked with other services to ensure they received relevant information about people's care. Staff contacted other agencies for support with people's care as required. The provision of people's care was co-ordinated with other services.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff had undertaken safeguarding training and understood their role and responsibilities. Safeguarding incidents had been identified, reported to relevant agencies and actions taken to reduce the risk of re-occurrence.

Risks to people were identified and staff understood and followed the guidance in relation to managing risks to people.

Sufficient staff were employed to provide people's care. Staff had undergone comprehensive pre-employment checks to assess their suitability.

Staff had completed medicines training and administered people's medicines safely. Staff competence was assessed through spot checks and competency assessments.

Is the service effective?

Good

The service was effective.

People were supported by staff who received an induction to their role and on-going support and training.

People's consent had been sought. Where people lacked capacity to consent their relatives had been consulted in accordance with legislative requirements or advocacy arranged. The provider had not documented in their assessment why they believed people lacked capacity, but planned to.

People's dietary preferences and requirements had been noted to ensure they received meals that met their requirements. People received sufficient food and drink to meet their needs.

Staff were alert to changes in people's presentation and ensured people accessed health care services as required.

Is the service caring?

Good

The service was caring.

People were cared for by staff whose caring aptitude had been assessed as part of their recruitment. People were provided with information about potential staff and chose who they wanted.

People's preferences about their care were known and understood by staff.

People's wishes were respected and staff treated them with dignity and respect.

People were supported to receive palliative care by experienced and trained staff. The provider was addressing the need to improve end of life planning for people.

Is the service responsive?

Good

The service was responsive.

People had personalised care plans which reflected their care needs and preferences with regards to the provision of their care. These had been updated regularly to reflect any changes.

Summary of findings

People's independence was promoted and they were supported to pursue their interests.

Changeovers in care staff were well managed. Staff had sufficient time for the handover and key information about people was passed on.

People were provided with information about how to complain. Complaints were logged, investigated and responded to. Changes to the service were made as a result of complaints received.

Is the service well-led?

Good

The service was well led.

Staff understood the provider's values and practised them in the delivery of people's care.

Staff were encouraged to speak up about any concerns they had about people's care. The registered manager monitored the quality of the service and took action where required to improve people's experience.

People's feedback on the quality of care they received was sought. Action was taken if issues were identified.

The service was well led by the management team at all levels.

Loga Care Limited

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014

This inspection took place on 2 and 5 February 2015 and was announced. Forty eight hours' notice of the inspection was given to ensure that the people we needed to speak to were available.

The inspection team comprised of one inspector, a specialist advisor and an expert by experience**.** The specialist advisor was someone who has clinical experience and knowledge of working with people who receive palliative care. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had personal experience of community services.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information included in the PIR along with information we held about the service, for example, statutory notifications. A notification is information about important events which the provider is required to tell us about by law.

Prior to the inspection questionnaires were sent to people, their relatives, staff and community professionals to seek their views of the service provided. Thirteen people, three relatives, 13 staff and three community professionals returned their questionnaires. We reviewed their responses to inform our planning of this inspection. We spoke with a person who used the service, an advocate, two social workers and a nurse about the service.

During the inspection the inspector spoke with one person and visited a further two people and their care staff at home. We spoke with three office staff, one care staff, the registered manager and the operations director. We reviewed records which included seven people's care plans, three staff recruitment and supervision records and records relating to the management of the service.

Following the inspection we spoke with three care staff on the telephone, visited three people and their care staff at home and spoke with 15 people by telephone.

Good

Is the service safe?

Our findings

All the people who responded to our questionnaire said they felt safe from abuse and harm from care and support workers. One person told us "I feel very safe. Staff are competent about processes." Another person told us they felt as "Safe as houses."

All the staff who completed our questionnaire stated they knew what to do if they suspected a person was at risk of harm. We spoke with three staff about safeguarding and they told us they had covered safeguarding procedures during their induction and they were required to update this training annually, which the records confirmed. Staff told us they had access to safeguarding polices and relevant telephone numbers to enable them to report any safeguarding concerns. Staff were able to demonstrate an understanding of their safeguarding responsibilities. People were kept safe as staff understood their role in relation to safeguarding procedures.

The registered manager had identified potential safeguarding situations and reported them to the local authority, which records confirmed. They told us following a safeguarding incident where people may have been placed at risk of harm. They had issued staff with revised guidance about record keeping to reduce the risk of this happening again. People were safeguarded as incidents were reported and changes made to staff practice as a result.

People's care plans stated if they required support with finances and who supplied this support. Where staff supported people, processes were in place to record this. People's visitors were listed in their care plan so staff were aware who was likely to be visiting the house and to alert them to potential risks from unfamiliar callers. People were protected as the provider was aware of potential safeguarding risks to people and had taken measures to manage them.

Risks to people had been identified in relation to safety, communications, memory, behaviour, sleep, medicines, pain, nutrition, washing, bathing, grooming, dressing, continence, skin care, mobility and social contact. Where risks were noted there were plans in place to manage them.

If a second care staff member was required to move people safely, this had been documented. There was also a record of the equipment needed and what the person could do. If a second care staff member was provided by another agency, the times they visited were stated. Records showed all staff had completed moving and handling training. Risks to people associated with moving and handling were managed safely.

Staff received guidance about how to manage the risk of people experiencing pressure sores and pressure relieving equipment was in place. One person had a pressure relieving mattress to sit on and another one for their feet. Care staff told us how they supported the person to move during the day to relieve the pressure and how they monitored the person's skin. The risks to people from the development of pressure sores had been managed effectively.

Staff had taken action and followed incident reporting procedures by completing body maps where any bruising had occurred, and reporting ongoing risks to office staff. Office staff had also taken action where necessary to mitigate risk for example, by consulting the person's GP.

Records confirmed contingency plans were in place for the winter weather. Staff had contact details of who they should contact depending on the type of emergency. Care staff had been emailed with an alert about expected bad weather and actions they should take in preparation.

A person said "I have consistency in my carers." The registered manager told us where possible they ensured consistency for people in staffing, although this was not always possible with relief care staff. Some people's care staff had been working with them for over a year. Records demonstrated the provider had an ongoing staff recruitment programme. A staff member said there were office staff who managed staff rosters. They ensured the office staff on duty had a list of available staff in the event they needed to make an urgent change to the care staff providing a person's support. There were sufficient staff to provide people's care.

Staff had undergone relevant recruitment checks as part of their application and these were documented. These included the provision of suitable references and a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. The operations director told us they recruited about 5% of the workforce from abroad.

Good

Is the service safe?

In addition to the DBS these staff were required to provide evidence they had undergone a police check in their country of origin, within the past three months. The provider took measures to ensure people's care was provided by staff who were suitable to work with vulnerable people.

A nurse told us there could be communication and cultural issues with staff. People we spoke with by telephone told us all the care staff were sufficiently fluent in English. A person's advocate told us the provider responded quickly if this was identified as an issue. Staff said applicants were now required to demonstrate their English language skills and understanding as part of the recruitment process, which records confirmed. The provider had taken action to ensure staff had the required level of communication and written skills for their role.

Records showed and the manager confirmed when issues had been identified in relation to staff. The registered manager had addressed them by requiring staff to undertake re-training or supervision or disciplinary action. People were protected as appropriate action had been taken.

A person said "Staff give me my medicines when I need them." Staff told us "I feel competent administering medicines." and "I read about what I am administering to people." Staff completed medicines training during induction, which records confirmed. Staff had access to the provider's medicines policy. The registered manager told us a staff medicine competency assessment was introduced in November 2014. We noted staff were only required to update their medicine training if they had made an error. We discussed this with the registered manager and the operations director. Following the inspection we received confirmation they were immediately introducing annual updates of medicine training for all staff in addition to the competency assessment.

We reviewed people's medicine administration records (MAR) and saw staff had signed to say what medicine had been administered. If a medicine was not administered, the reason and any action taken as result were recorded. Records showed people's MAR's were audited when returned to the office. If errors were found then the staff member received further medicines training or spot checks of their work. People's MAR's were audited and appropriate action taken.

A care staff had checked with the pharmacy about how to administer a new drug, which the person had recently commenced to ensure they administered it correctly. Another had checked with nurses before omitting a medicine to ensure they were following the instructions correctly, they included the person with this decision. People's care plans were altered in accordance with any new medicines or instructions from the GP. People's medicines were administered safely.

Good

Is the service effective?

Our findings

All staff who completed our questionnaire confirmed they had completed an induction. The registered manager said the provider had increased the staff induction to three days to ensure a more effective preparation for their role. Staff told us they had completed the Skills for Care common induction standards which are the standards people working in adult social care need to meet before they can safely work unsupervised. People were cared for by staff who received an appropriate induction to their role.

Staff who provided palliative care had completed on-line training and two staff were undertaking further training. A staff member said they had completed training in mental health awareness. A staff member was due to attend a moving and handling train the trainer course, to enable them to provide in-house training. One staff member said "Learning is encouraged I have been asked to do Qualifications and Credit Framework (QCF) level two." Six office staff were enrolled on the QCF level three diploma. QCF's are work based awards which replaced National Vocational Qualifications (NVQ's). They are achieved through assessment and training. To achieve an award, candidates must prove that they have the ability (competence) to carry out their job to the required standard. The registered manager told us they were arranging for care staff to undertake the level two diploma, which records confirmed. People received care from staff that were supported in their professional development.

The operations director told us the number of staff supervisions and spot checks had increased. These involved senior staff assessing the quality of care staff work. The majority of staff had either received supervision and an annual appraisal of their work, or these had been arranged. Staff said "The office is very supportive we get all the information we need." Staff were supported in their role.

All but one person we spoke with by telephone said the care staff asked for their consent before they did anything. All staff who completed our questionnaire confirmed they had had training in the Mental Capacity Act (MCA) 2005. The MCA provides a legal framework for acting and making decisions on behalf of people who lack the mental capacity to make particular decisions for themselves. Staff demonstrated an understanding of the principles of the act and described how they supported people to make decisions. People were cared for by staff who had received relevant training.

A social worker told us staff were able to assess people's capacity. The provider had a copy of the local authority guidance to support them in any formal recording of mental capacity assessments and best interest decisions. One staff member told us following a mental capacity assessment of a person they found they lacked capacity to consent to an operation and therefore requested further assessment by a professional. If people lacked the capacity to decide to receive care, their relatives had been consulted about their best interests. In people's files it was unclear in documented assessments how decisions about people's lack of mental capacity had been reached. It is good practice to keep a record of the steps taken to determine if a person lacks capacity in relation to a specific decision. We discussed this with the registered manager who advised us they would be formally recording these assessments.

The provider had obtained copies of people's lasting power of attorney. A LPA is a legal document that lets a person appoint one or more people (attorney's) to make decisions on their behalf. They can be in relation to health and welfare or property and financial affairs. This ensured the provider knew who was legally able to make decisions on people's behalf and in relation to what type of issues. If people were subject to the Court of Protection (CoP) the provider had recorded this. The CoP makes decisions on applications which involve people who lack mental capacity. People were supported by staff who understood who was legally able to make decisions on their behalf.

The registered manager told us they had attended training on the Deprivation of Liberty Safeguards (DoLs), records confirmed this. The Care Quality Commission (CQC) monitors the operation of the DoLs which applies to community services. The registered manager was aware of a Supreme Court judgement which widened and clarified the definition of a deprivation of liberty. They told us of how they were working with social services to identify if an application should be made for one person. People were protected as relevant staff understood the DoLs.

One person told us "We discuss the meals and I have what I want." Care staff told us what the person's food preferences and dislikes were. People's care plans contained clear information about what they ate and drank, and their likes

Good

Is the service effective?

and dislikes. Care staff documented what they planned with/for people, for each meal and what they ate. If people had any specific dietary requirements, preferences or food allergies these were noted. People had food and fluid charts in place where required. The provider was aware that many care staff had a different cultural background from the people to whom they were providing care. To enable them to prepare appropriate meals care staff were provided with a recipe book to give them guidance.

A person occasionally had problems with swallowing and clear advice was detailed for staff with regard to cutting the food up into small pieces, and sitting them up to avoid the risk of choking. Another person's care plan said they required pureed food. They and their care staff both confirmed this was how food was provided. A person who experienced dementia was seen eating their breakfast. Staff ensured they had the equipment they required to eat breakfast safely. They had a tray at the correct height for them and a straw for their drink. They had been given a choice of jams and enjoyed buttering their own toast. People received appropriate support with eating and drinking.

One person told us "If you are medically unwell they are good at responding." Another person told us they felt their day to day health needs were well managed. They told us they had access to the GP whenever they wished. A staff member told us they had noted a change in a person's presentation. They reported this to the office who arranged for a GP review. Where people had a learning disability or experienced dementia we saw evidence they had a hospital passport in place detailing information hospital staff would need to be aware of in order to support the person in the event of their admission.

A social worker said people were supported to attend healthcare appointments. There was evidence people had been reviewed by their GP and nurse. Records showed staff had met with a community learning disability nurse to receive advice and support with regards to how to support one person. If people required support from staff to complete physiotherapy exercises there was guidance in their care plan. A staff member told us how they worked with the physiotherapist to support the person to undertake their exercises. People were supported to maintain good health and to access healthcare services as required.

Good

Is the service caring?

Our findings

A person told us "Staff are caring." A social worker said staff had a good relationship with people.

The registered manager told us whilst potential applicants completed their interview and induction they stayed in the provider's accommodation and were monitored, to assess how they interacted with others. The registered manager said if they had any concerns about candidate's ability to get on with people they were not offered employment, which was confirmed by records. People's care was provided by staff whose caring behaviours had been assessed as part of their recruitment.

A person told us "I get a carer profile." The registered manager said office staff matched staff to people's requirements. Records showed each care staff member had a biographical profile which provided people with information about them, to enable them to make their choice of staff. People's care was provided by staff they chose.

Staff told us they received people's care plan 48 hours before the placement started so they could read it. Staff told us some people had 'All about me' booklets. These are a resource for people who experience dementia to provide care providers with information about themselves. Staff were provided with relevant information about people they were going to provide care for.

A member of care staff supported a person who could no longer speak. They understood how this person articulated or showed dislike, displeasure, and discomfort, and addressed the issue. They changed their position, altered their drink, or made environmental changes such as turning the TV on or off. One care staff told us they were working with a person who was resistant to personal care. They said they had built up sufficient trust so that the person now allowed themselves to be washed. One person had only had their care for a week and yet we saw they had trust in the care staff and had formed a bond with them. The person told us "She treats me how I like." People greeted office staff warmly, they knew them well. People were cared for by care staff and office staff who had developed caring relationships with them.

A person said "I am involved in my care." All of the people who responded to our questionnaire said they were involved in decision-making about their care and support needs. A nurse told us the content of people's care plans demonstrated their involvement. A person's lay advocate said the provider had referred people to advocacy services where they had identified people required this support. A lay advocate is a person who assists the person to represent their interests. People were supported to be involved in decisions about their care.

The registered manager told us staff planned care with people and focused on the person's description of how they wanted their care provided. People's care plans noted their preferred method of communication. A person's care plan gave guidance about how to support a person from the sitting to standing position. The care plan told staff what information they should give the person to support them. People's preferences about terms of address, bathing arrangements, times they liked to get up and go to bed were noted. A staff member told us about the preferences and dislikes of the person they were about to start a placement with. People's care plans reflected how they wanted their care provided.

One person wanted to be consulted about a particular aspect of the management of their home and staff had written guidance to ensure the person's wishes were followed. A staff member told us the person they were placed with did not like having office staff visit and did not want spot checks on staff in their home, this was respected. People's wishes were recorded and followed.

All of the people who responded to our questionnaire said their care and support workers always treated them with respect and dignity. A social worker said staff respected people's space and recognised they were living in the person's home. Staff were seen to respect people's homes and checked if people wanted them to remain present or to leave when we spoke with them. People chose to have care staff present, but staff were seen to remain at a discreet distance. People were well presented in clean, well-fitting clothes. A staff member described to us the measures they took to protect people's dignity whilst they provided their care. This included ensuring people were covered whilst personal care was provided. People's dignity and privacy were respected and promoted by staff.

One member of office staff was allocated to co-ordinate people's palliative care packages. Palliative care is the

Good

Is the service caring?

active holistic care of patients with advanced progressive illness. The provider worked closely with health care services to support people's wish to receive palliative care at home.

A staff member who worked with people who required palliative care told us "I have done a couple of courses in palliative care and I have experience." The operations director said as a learning point following a safeguarding incident they had recruited staff with experience of palliative care and only experienced staff were placed with people requiring this type of care. They also said they were in the process of arranging for an office staff member to be trained to enable them to provide in-house palliative care training for care staff in addition to the on-line training provided. People were cared for by staff who were experienced and trained.

Staff were trained in Do Not Attempt Resuscitation (DNAR) guidance, as part of their end of life awareness training and we saw DNAR's were in place for people where required. The provider had an end of life care plan form, but on people's care plans we reviewed this had not been completed. There was no predictive care plan to support care staff with what to do in case of a person experiencing a sudden health crisis which could result in their admission to hospital if their wishes were not recorded. We raised this issue with the operations director who told us they had plans to train staff in The Gold Standards Framework. This aims to train staff to provide a gold standard of care for people nearing the end of life. This would assist staff to plan care with people that were nearing the end of their life, but had not yet actively entered the dying process. Staff were supporting people to receive palliative care at home and the provider was arranging staff training to enable them to further support people in their end of life care planning.

Good

Is the service responsive?

Our findings

Two people told us they had been involved in their care planning. One said "My care plan reflects me. I have been consulted throughout and it is regularly updated." All of the people who responded to our questionnaire said if they wanted them to, the care agency would involve the people they chose in important decisions.

People's care records demonstrated their needs had been assessed prior to them being offered a service. Office staff told us they provided the person with an initial care plan and risk assessment. Then they re-visited the person after a couple of days, to gather feedback, make amendments and to add additional information which had been obtained from the first few days of the person's care. A care staff said "The first couple of days I observe to see how they are." Another care staff told us "The care plans are fluid and have to be updated." Records showed people's care had been regularly reviewed. People were involved in the initial assessment of their needs and their care plans were updated as required.

Care plans were detailed and personalised to support the person's care and treatment. One person's plan documented they were not able to clearly express their pain. Care staff were asked to monitor the person's reactions and be aware for actions that might indicate pain. This ensured staff were alert to the need to monitor if this person experienced pain. Where people experienced behaviours which could challenge staff care plans provided detailed guidance on the person's behaviours, triggers, and actions they should take to support the person. People's care plans reflected the level and type of support they required.

All of the people who responded to our questionnaire said the support and care they received helped them to be as independent as they could. One care staff member said "I try my best to enable the person to be in charge." A person told us they felt their care staff were sensitive to them having control of their life. They felt staff assisted them to make choices. Care staff went on regular weekly excursions with them and they felt they were living their life how they wished. Another person had been supported to go on holiday by staff. People's independence was supported.

People's hobbies and interests were noted in their care plan and how they could be supported to pursue them. A person told us care staff supported them to go to church if they wished. They also said they liked to go out to garden centres. This information about their interests was reflected in their care plan. Another person was supported to follow their interests with the provision of suitable care staff, who could tell jokes, understand their perspective, and escort them on outings as requested. One person's care plans provided staff with guidance on how to support the person not to become socially isolated. People received appropriate support.

A social worker said when there was a change in care staff there was a thorough handover of the person's care between staff. A person told us "I am involved in my handover." A care staff member said they received a two hour handover when there was a change in staff. Care staff completed a handover sheet as part of the handover process. The checklist covered areas such as introductions, food, person's history, routine, medicines and finances. People experienced smooth, documented transitions of care between staff.

A person said "If I want something I call the office and they are responsive." A person's advocate and a nurse confirmed this. Spot checks completed by office staff had been used to identify any improvements which could be made in relation to people's care. Office staff had noted during one check the person would benefit from information about changes to care staff being provided in a pictorial format and this had been provided. Office staff had identified and responded to this person's needs.

All but one of the people who responded to our questionnaire said they knew how to make a complaint about the provider. All but one person told us their care staff responded well to any complaints raised. All of the people we spoke with said they all knew how to raise a concern or complaint. One person said "If I said the care wasn't working out they would try and address that or change the carer."

People were provided with a service user guide, which included information about the compliment and complaints procedure. The registered manager said they had undertaken training with staff on complaints management to ensure they understood their role. A staff member told us people were given a complaints form and described how they would support people with this process. People were given information about how to make a complaint and staff understood their role.

Good

Is the service responsive?

Records showed all complaints whether verbal, written, from the person, their family or professionals had been logged, investigated and where required action had been taken. The registered manager gave us an example of a complaint they had received and responded to. The person had made a request about their care which they felt staff had failed to meet fully. The provider had listened to their concerns, amended their care plan accordingly and ensured the person's requirements were met through the staff rostering system, records confirmed this. Records showed the provider had met with another person's family in response to concerns raised. This enabled the family to openly express and discuss the issues. People's complaints had been logged investigated and responded to appropriately.

The registered manager told us they had identified themes from their complaints analysis. This included the need to improve recording and reporting, improve training and that staff had not always followed people's care plans accurately. In response they had increased the length of the induction training programme. They had increased the emphasis in staff training on recording and reporting, and the importance of reading and following the care plan. People's care had improved as learning and improvements were made as a result of complaints received.

Good

Is the service well-led?

Our findings

Everyone we spoke by telephone felt the service was well managed. All but one of the people who responded to our questionnaire said they knew who to contact in the service if they needed to. All of the professionals who responded to our questionnaire said the service's managers and staff were accessible, approachable and dealt effectively with any concerns. A person's advocate and a social worker told us there were good communications from management. The majority of people and professionals told us there were positive communications with the office.

Three staff we spoke with about the values and ethos of the service confirmed these had been discussed with them during their induction and they were aware of them. Staff were provided with a handbook which covered the principles and values of the service. Staff demonstrated their understanding of the values of the service through their behaviours. Staff were observed to treat people with kindness, respect and dignity. One staff member said the independence and well-being of people was of paramount importance to staff, and in the company ethos. People were cared for by staff who understood and practised the values of the service in the provision of their care.

A staff member said "We can contact the office as we wish to raise issues and there is no comeback. There is open communications between the office, clients and staff." Another told us they had raised a concern which they felt had been listened and responded to appropriately. Details of the whistleblowing policy were available to staff. People were supported by staff who were encouraged to raise issues.

The registered manager said when they commenced work there was a culture of under reporting of adverse incidents. They had identified staff did not always understand what they should report. They said they had been working with staff on the importance of reporting all incidents. Records showed this had been addressed with staff via emails, newsletters and with individual staff. Work had also been completed with staff in relation to record keeping, which was confirmed in documentation we looked at. A member of staff said "We are taught how to record." One recently employed staff member told us when they commenced work they had not completed medicines paperwork in accordance with the provider's policy. They felt they had been shown very quickly how to do this in a constructive and motivating manner. People's care was provided by staff who received constructive feedback.

The ownership of the company who provided the service and the registered manager had changed in the past six months. One staff member felt the provider was "Really good, really good" at demonstrating good leadership and management. Another said there was "Good, considerate management." A staff member told us there had been a change in leadership and they noted information was now better documented. The operations director told us they had been in post since October 2014 and spent two days a week on-site at the location. This ensured they had oversight of the day to day operation of the location. Staff were supported by visible, accessible and supportive management.

The registered manager and the operations director understood the issues the service experienced in relation to managed growth and recruitment. The operations director was aware that as the business was growing they required the infrastructure to support growth. Staff roles were becoming more specialised with one office staff member having responsibly for palliative care. There was an increase in the number of field based supervisors monitoring people's care. They were implementing a new IT system to support staff rostering. People's care was provided by a management structure that was managing the growth of the service effectively.

A person told us "The agency have rung through to check on the care." Two people confirmed they had been sent questionnaires to complete about the quality of the service they received. One person said office staff rang and checked they were satisfied after each changeover of care staff.

Records showed people had received a telephone call regarding the care they received each time there was a changeover of care staff. Where people were prepared to receive spot checks of their care these had been completed. Spot checks covered aspects of the service such as: staff presentation, care support plans and records, moving and handling, communication and household. If changes were required as a result of checks these were noted and any actions taken. The operations director told us they were planning the next quality survey which was to

Good

Is the service well-led?

be sent to people, their families and professionals imminently and this would be followed with an action plan. People were asked for their views of the service they received.

The operations director told us they submitted a monthly report to the provider covering areas such as complaints and compliments, safeguarding, accidents and incidents, recruitment and staffing. Records confirmed this. The monthly report ensured the provider was aware of information which impacted on the quality of the service people received. They told us that as part of the business plan they were looking at the introduction of internal audits of people's records. This would enable them to further assess the quality of service people received in addition to their current methods. The quality of care people received was monitored.

The provider had obtained copies of relevant assessments from other agencies when people were first referred to the service to enable them to understand the person's needs and if they were able to meet them. Records confirmed this. Care staff told us how they liaised with other agencies in the provision of people's care such as social services and healthcare. Staff had completed joint visits to people with other agencies, professionals and people's advocates. A person had been assessed by an occupational therapist and their guidance on moving and handling the person had been incorporated into their care plan. A staff member was able to tell us how a person needed support to alleviate pressure areas. They said they reported this to the office who rung the occupational therapist immediately. They then visited and arranged appropriate equipment. The person's care plan was updated to reflect the guidance provided. The provider ensured the provision of people's care was planned with other agencies.

Following a safeguarding incident last year the provider had ensured close liaison with other services to plan for people's discharge from hospital. When they identified people's discharge had not been completed as planned they alerted relevant services to ensure incidents could be investigated. People benefited as the provider had advocated on their behalf to plan joined up care in relation to hospital discharges and had taken action when this did not happen as proposed.